2015

BENEFITS ENROLLMENT GUIDE

Rutherford County Tennessee

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START HERE

What's in this guide?

This guide explains what you need to know about enrolling for your 2015 benefits. It's organized in an easy-to-follow Q&A format.

Do I have to go online during Annual Enrollment?

You are strongly encouraged to go online to review and confirm your benefits. There are changes for 2015 that could affect your current elections.

How do I enroll?

See page 2 for enrollment instructions.

Is there a deadline to enroll in a plan or make changes to an existing plan?

Yes. The Annual Enrollment period to elect benefits, make benefit changes or confirm existing benefits begins at 8:00 a.m., Monday, October 20, 2014, and ends at noon, Monday, November 3, 2014.

What if I need more information than this guide provides?

Visit **www.rutherfordcountytn.gov/rm** for more details on benefit plans, including summary plan descriptions. (Click Employee Insurance Benefits on the left side of the screen.) Additional information is enclosed in this packet.

This brochure is intended to provide highlights of Rutherford County's benefits program. It is not intended to include all of the benefit plan details. The complete details about how the plans work are included in the plan documents, which are available at ***www.rutherfordcountytn.gov/rm****. If there are any differences between the information in this brochure and the plan documents, the plan documents will govern the employee's rights to benefits in all cases. This document does not constitute a contract or offer of employment. Rutherford County reserves the right to change or end any of the plans or programs described in this brochure at any time. If you have any questions about Rutherford County's benefits program, contact the Risk Management Department.*

WHAT'S NEW FOR 2015?

VISION COVERAGE NO LONGER INCLUDED WITH MEDICAL PLAN

Vision coverage will no longer be included as part of your medical coverage. It will be offered as a separate, standalone plan with the same benefit levels as provided in 2014. If you want vision coverage in 2015, you must elect it separately; if you don't enroll for it, you and your dependents will not have vision coverage effective January 1, 2015. If you elect vision coverage, you will receive a Cigna Vision ID card in the mail. See page 12.

MEDICAL FSA OFFERS CARRYOVER

If you participate in the Medical Reimbursement Account (FSA), you may carry over up to $500 of unused funds into the next plan year. In other words, if you overestimate your health care expenses for 2014 and have money remaining in your account at year-end, you may carry over up to $500 and continue to incur and get reimbursed for eligible expenses from the carried-over amount. Any amount over $500 will be forfeited.

The carryover provision does not reduce how much you can contribute to the Medical Reimbursement Account (FSA) in the next plan year. For example, if you carry over $400, you can still make the maximum contribution ($2,500) in the next plan year.

If you participated in an FSA last year, your TASC debit card will be reloaded with your 2015 contributions. New enrollees will receive an FSA debit card from TASC mailed to their home addresses.

Important: Unused funds exceeding the $500 rollover limit will be forfeited.

LIMITED LIFE INSURANCE INCREASES ALLOWED DURING ANNUAL ENROLLMENT

During Annual Enrollment only, you may elect or increase your supplemental life by $10,000 and/or your spouse's supplemental life by $5,000, with no medical questions asked. (Spouse supplemental life is limited to 50% of employee's amount.) See page 13 for more details.

VOLUNTARY PLANS AVAILABLE DURING ANNUAL ENROLLMENT ONLY

If you were hired after October 1, 2013, you have four new voluntary insurance plans available to you: cancer, critical illness, accident and LifeTime Benefit Term insurance. These plans can only be elected during Annual Enrollment; coverage is guaranteed with no medical questions asked.

If you're a current employee and previously declined this coverage, you may elect it during Annual Enrollment; however, you must answer medical questions and be approved by the insurance carrier. See pages 18-19.

MEDICAL OUT-OF-POCKET MAXIMUM NOW INCLUDES COPAYS

See the footnotes on pages 4-5 for details.

MEDICAL PLAN CONTRIBUTIONS INCREASING

Employee contributions for all plans will increase starting January 1, 2015, with one exception: Under the HRA plan, employee-only coverage will continue to have no employee contributions. See 2015 medical rates on page 8.

DENTAL PLAN CONTRIBUTIONS INCREASING

Employee contributions for all dental plans will increase. See 2015 dental rates on page 11.

HRA PLAN ENROLLEES CAN USE MED POINT CLINICS AT NO COST

Employees and family members enrolled in the HRA plan can now use the Med Point medical clinics and Walgreens clinics for both preventive and non-preventive care at no cost.

ENROLLMENT AND ELIGIBILITY

ENROLLING FOR BENEFITS

When is Annual Enrollment?

Annual Enrollment starts at 8:00 a.m., October 20 and ends at noon, Monday, November 3 , 2014.

How do I enroll?

To enroll online, follow these steps:

1. Sign on.

- Using any computer with Internet access, visit the ADP website at **https://adp.eease.com**. The process is case-sensitive.
- Enter the following:
  - User Name: **rc** (lowercase) plus last 6 digits of your Social Security number
  - Company Identifier: **rutherford** (lowercase)
  - Password: First and last initials (uppercase) plus birth date MMDDYY
- Example:
  - For: John Public; SSN: 388-11-2222 birthdate: May 30, 1978
  - Login will be:

    User name: rc112222

    Company Identifier: rutherford

    Password: JP053078
- On the welcome page, selecting "Walk me through the process" will allow you to view each benefit plan and decide whether to continue, elect, decline or withdraw participation.

2. Choose your benefits.

- Follow the prompts to review/change your benefits.
- If you're enrolling dependents, make sure they are listed under each applicable benefit plan with their Social Security numbers. If not, click Add a Dependent. Do not duplicate or add a dependent who already exists in the online enrollment system.
- If you enroll for life and/or AD&D, you must designate a beneficiary(ies) and applicable percentage(s); otherwise, benefits are paid to your estate.

3. Complete your enrollment.

- View your Benefits Summary. If you are satisfied with your elections, click Submit to Administrator. You can change your elections until noon, Monday, November 3.
- Print a Benefits Statement for your records (choose "Print Benefit Statement as of _____."). In the blank box, type 01/01/2015. This is a summary of your elections and not a guarantee of coverage.

What happens if I select the "Accept With No Changes" box?

If you check this box, your coverage will continue in 2015 with the following exception: Your participation, if any, in the Medical and/or Dependent Care Flexible Spending Accounts will end December 31, 2014. **If you had vision coverage in 2014, you will not have it in 2015.**

What if I want to drop coverage in one or more plans?

Once you log on to the ADP website, review each of your plan elections and select the "decline" box for the plan(s) you wish to drop.

What if I don't have Internet access?

A computer may be provided at your work location, or you can use the Risk Management Department's computer kiosk.

When does coverage begin?

Coverage elected during Annual Enrollment becomes effective January 1, 2015.

ENROLLING DEPENDENTS

Can I enroll my spouse and/or children for coverage during Annual Enrollment?

If you are eligible for coverage, you can also enroll your spouse and/or eligible dependent children for medical, dental, vision, spouse and/or child life insurance, spouse AD&D, and critical illness, cancer and accident insurance. You must provide documentation proving that your dependents meet eligibility requirements.

How do I know if my dependents are eligible?

Eligible dependents include:

- Your legal spouse (or domestic partner for life insurance only)
- Your children (or stepchildren) by birth, marriage, legal adoption or legal guardianship
  - **For medical coverage:** in accordance with health reform, up to age 26, regardless of marital or student status (excludes spouses and dependents of the eligible dependent child)
  - **For dental and vision coverage:** not covered under health reform, up to age 19 (up to age 25 if unmarried and a full-time student; proof of student enrollment is required)
- Your children of any age who became totally and permanently disabled before age 19 while covered by the plan(s)
- Dependents covered under a Qualified Medical Child Support Order (proper documentation required)

For more information about eligibility, see your summary plan description.

What documentation proving my dependents' eligibility is required to add them to my coverage?

For a list of required documentation, go to **www.rutherfordcountytn.gov/rm/benefits.htm** and click on List of Acceptable Documents for Verification.

Where and when must I submit this documentation?

Documentation for adding a spouse and/or any eligible dependent child must be received in the Risk Management Department **no later than 4:30 p.m., Monday, December 1, 2014**. You may submit your documentation via fax to 615-867-4602.

Important: You will NOT be contacted by the Risk Management Department requesting this documentation. This is the employee's responsibility.

What if I fail to provide the required documentation by the deadline?

If documentation is not provided by the deadline, coverage for the dependent will be denied.

My spouse also works for the County/Board of Education. Can we both enroll in our own medical, dental and/or vision coverage?

If you ARE NOT covering dependent children, each spouse may elect "employee-only" medical, dental and/or vision coverage. If you ARE covering dependent children, you must follow these rules:

- You may not elect duplicate coverage for any family member. For example, husband and wife cannot cover each other. Husband and wife cannot both cover the same eligible dependent children.
- Medical, dental and/or vision coverage for dependent children CAN be split between the father and mother.

Here are two examples of allowed enrollment:

- Father elects "employee-only" medical, dental and vision coverage, and mother elects "employee + children" medical, dental and vision coverage and covers all children.
- Father elects "employee + children" coverage and covers their son. Mother elects "employee + children" coverage and covers their two daughters.

If you are currently violating eligibility rules, you must correct it during 2015 Annual Enrollment to prevent further action, which may include loss of insurance. Contact Risk Management at 615-898-7715 for assistance.

CHANGING YOUR BENEFITS

Can I add, drop or change my (or my dependents') coverage during the year?

Generally, you cannot change your benefit elections during the year unless you experience a life status change, such as a marriage, divorce, birth, adoption, or a gain or loss of coverage by your spouse or dependent child. For a complete list of life status changes (as governed by IRS Code 125), visit **www.rutherfordcountytn.gov/rm/benefits.htm**.

You must notify the Risk Management Department within **30 calendar days of any change in status**, and documentation is required within the same timeframe. If you miss this deadline, your change request will be denied.

MEDICAL

The County offers you a choice of medical options, administered by Cigna:

- OAP Copay plan
- OAP Deductible plan
- Health Reimbursement Account (HRA) plan.

Do I have to use certain medical providers?

You can see any medical provider you choose, but benefits are highest when you use a provider in Cigna's network.

Preventive care is not covered out-of-network.

How do I find in-network providers?

All three medical options use Cigna's Open Access Plus (OAP) network. Visit **www.cigna.com** or call 1-800-244-6224 for a list of in-network providers.

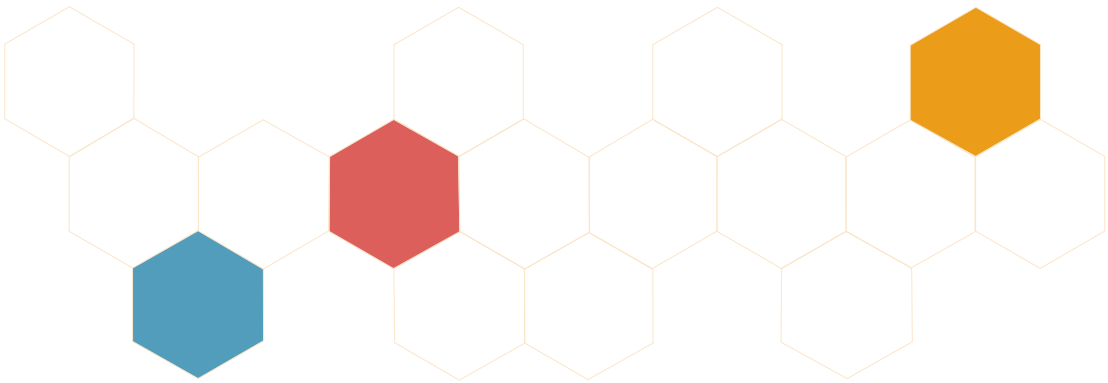
How much do the medical options cover?

This chart below shows benefit levels for each medical option. Turn the page to learn more about each option.

	OAP Copay plan	
	In-network	Out-of-network
Annual deductible	$1,000/person $2,000/family	$2,000/person $4,000/family
HRA contribution (HRA plan only)	N/A	N/A
Annual out-of-pocket maximum	$4,000/person $8,000/family	$8,000/person $16,000/family
Plan pays...		
Office visits	100% after $30 (PCP) or $50 (specialist) copay[1]	60% after deductible
Preventive care	100%; no deductible	Not covered
Med Point medical clinics	100%	N/A
Hospital care	80% after deductible	60% after deductible
Emergency room	100% after $300 per visit copay[2]	
Urgent care	100% after $60 copay[1]	60% after deductible
Chiropractic care (26 visits per year)	80% after separate $150 deductible[1]	60% after separate $150 deductible[1]
Prescription drugs	See page 7	

[1] Copays and deductibles apply to your annual out-of-pocket maximum.

[2] Copay applies to your annual out-of-pocket maximum; if hospitalized following an ER visit, copay is waived and annual deductible and coinsurance applies.



What happens to my medical coverage if I don't re-enroll?

You are strongly encouraged to go online to review and confirm your benefits. There are changes for 2015 that could affect your current elections.

OAP Deductible plan		HRA plan	
In-network	Out-of-network	In-network	Out-of-network
$500/person $1,000/family	$1,000/person $2,000/family	$1,750/single $3,500/family collective	$3,000/single $6,000/family collective
N/A	N/A	$750/single; $1,500/family	
$2,500/person $5,000/family	$5,000/person $10,000/family	$5,000/single $10,000/family collective	$10,000/single $20,000/family collective
80% after deductible	60% after deductible	90% after deductible	60% after deductible
100%; no deductible	Not covered	100%; no deductible	Not covered
100%		100%	
80% after deductible	60% after deductible	90% after deductible	60% after deductible
100% after $300 per visit copay[2]		90% after deductible	
80% after deductible	60% after deductible	90% after deductible	60% after deductible
80% after separate $150 deductible[1]	60% after separate $150 deductible[1]	90% after deductible	60% after deductible
See page 7		See page 7	

MEDICAL continued

How do the Copay and Deductible options differ?

Both are Open Access Plus plans (OAPs), which center around a network of providers and facilities that provide medical services at a discount. These are known as in-network providers. Here are some key differences between the plans:

- The Copay plan has lower monthly premiums but a higher annual deductible and out-of-pocket maximum.
- The Copay plan covers office visits and certain other services at 100% after you pay a copay (generally $30 or $50 per visit).
- Under the Deductible plan, office visits and other eligible services are subject to the deductible and coinsurance.
- The two plans cover brand name drugs differently. See the chart on page 7.

How is the HRA different?

The HRA is a health reimbursement account. This plan takes a different approach to health insurance:

- **Lower payroll deductions** — the County pays the entire cost of employee-only coverage. And if you cover dependents, your payroll deductions are significantly lower than deductions for the Copay and Deductible plans.
- **A County-funded account** — the County makes an annual contribution to an HRA in your name ($750/single or $1,500/family) that you can use to pay for qualifying medical expenses or to help meet your deductible. If you don't use all your HRA money in a given year, it may roll over to the next, but may not exceed 100% of the deductible. The fund is not eligible to be transferred to your FSA nor can it be used as an FSA.

How does the HRA work?

Here's how the HRA works in four easy steps:

1. The money in your HRA automatically pays for your eligible medical expenses, such as doctor visits and prescription drugs.
2. You are responsible for 100% of eligible charges until the deductible is satisfied. Your County-funded HRA can help offset these costs.
3. Once you meet your deductible, the plan pays 90% of the cost of eligible medical services when you use in-network providers; you pay the other 10%. The family deductible and out-of-pocket maximum can be met by one or more family members.
4. If the amount you've spent (including the deductible and your HRA money) reaches the out-of-pocket maximum, the plan pays 100% for the rest of the year.

PREVENTIVE CARE IS FREE!

Prevention is about catching small health issues before they become bigger problems down the road. So take advantage of preventive care services. When you use in-network providers, most preventive services are free, with no deductibles or copays. See page 7 for details.

Is preventive care covered under the medical options?

Yes. All three medical options cover preventive services at 100% — no deductible or copay required — when you use in-network providers. This means you pay nothing for services recommended by the U.S. Preventive Services Task Force like:

- Age-appropriate health screenings (e.g., cholesterol, blood pressure, colorectal cancer, depression, diabetes, obesity, osteoporosis)
- Preventive care and screenings for infants and children
- Preventive care and screenings for women (e.g., breast cancer screening, cervical cancer screening)
- Preventive care and screenings for men (e.g., PSA test)
- Immunizations for adults and children
- Flu and pneumonia shots
- Annual exams (including associated x-rays and lab)

Exception: A preventive care service must be billed by the provider as preventive care to ensure 100% coverage. If a preventive service is billed separately from an office visit, you may be required to share in the cost of the office visit. For example, if you seek a preventive service such as an annual well-woman exam (Pap) or well-man exam (PSA test) and also receive some other kind of treatment (such as care for a sinus infection), cost sharing may apply to your office visit. In other words, the preventive care portion of the visit will be covered at 100%, and the illness portion may be covered with applicable cost sharing.

Preventive care is **not** covered out-of-network.

How are prescription drugs covered?

All three medical options include coverage for prescription drugs, as shown in the chart below:

	OAP Copay	OAP Deductible	HRA
Plan pays…			
Network retail pharmacy (up to 30-day supply)			
Generic	100% after $5 copay		70% after medical deductible
Preferred brand	100% after $30 copay	80%; no deductible	60% after medical deductible
Non-preferred brand	100% after $60 copay	65%; no deductible	50% after medical deductible
Tel-Drug mail order (up to 90-day supply)			
Generic	100% after $12 copay		75% after medical deductible
Preferred brand	100% after $75 copay	85%; no deductible	65% after medical deductible
Non-preferred brand	100% after $150 copay	70%; no deductible	55% after medical deductible
Annual out-of-pocket maximum	$1,250/person $2,500/family	$1,250/person $2,500/family	Included in medical maximum

MEDICAL continued

How much does medical coverage cost?

Your monthly cost for coverage, shown in the chart below, is deducted from your paycheck on a pre-tax basis (post-tax deduction is not an option for the OAP Copay or HRA plan).

Monthly premium	County (based on 12 months)			Board of Education* (based on 10 months)		
	OAP Copay	OAP Deductible	HRA plan	OAP Copay	OAP Deductible	HRA plan
Employee	$51.32	$58.98	$0	$61.58	$70.78	$0
Employee + spouse	$150.87	$173.41	$23.45	$181.04	$208.09	$28.14
Employee + child(ren)	$132.91	$152.76	$13.77	$159.49	$183.32	$16.53
Employee + family	$208.34	$239.47	$43.18	$250.01	$287.37	$51.81

* Board of Education (BOE) employees pay their insurance premiums over 10 months (September-June) for 12 months of coverage (September-August). BOE employees may be subject to collection of back premiums, known as "arrears." This is the amount needed to fully pay up July and August insurance. This occurs if an employee changes his/her medical or dental option or coverage tier, resulting in a higher monthly premium than previously enrolled. It can also occur if premiums increase for the new calendar year, or if an employee not enrolled in 2014 adds coverage for 2015. Alternatively, a refund will be issued if an employee makes a coverage change resulting in a lower monthly premium or drops coverage for 2015. Arrears/refunds will be administered through the payroll function. The timeframe for arrears/refunds will be February-April 2015.

Will I receive new Cigna medical ID cards for 2015?

You will only receive new medical ID cards if you are a new enrollee for 2015 or elect a different medical option.

I need help choosing a medical plan. Where can I find more information?

Check out "Choosing a medical plan" on page 9 for some things to consider before you enroll.

Also, visit **www.mycignaplans.com**; ID: Rutherford2015; Password: cigna — the log-in is case-sensitive. This site has benefit summaries for each medical option, which show a more detailed list of covered services, benefit levels and potential out-of-pocket costs.

USE MAIL ORDER AND SAVE.

Are you interested in lower out-of-pocket prescription drug costs and the convenience of shipped-to-your-mailbox service? If you take medicine for an ongoing medical condition, such as high blood pressure, high cholesterol, allergies or diabetes, save money on maintenance meds for these conditions and more by ordering 90-day supplies through Tel-Drug's mail order program. See page 7 for details.

CHOOSING A MEDICAL PLAN

Which medical plan is right for you?

Consider what's coming out of your paycheck. Look how much you could save on payroll deductions if you choose the HRA plan instead of the Copay plan.

	Payroll deductions (per month)				YOU SAVE		
	Copay plan		HRA plan		Per month		Per year
	County	Board of Ed.	County	Board of Ed.	County	Board of Ed.	
Employee	$51.32	$61.58	$0	$0	$51.32	$61.58	$615.84
Employee + spouse	$150.87	$181.04	$23.45	$28.14	$127.42	$152.90	$1,529.04
Employee + child(ren)	$132.91	$159.49	$13.77	$16.53	$119.14	$142.96	$1,429.68
Family	$208.34	$250.01	$43.18	$51.81	$165.16	$198.20	$1,981.92

When you choose family coverage in the HRA plan, you save nearly $2,000/year on premiums!

Don't forget the County's HRA contribution. When you choose the HRA plan, the County gives you tax-free money annually, called HRA contributions. This money gives you a boost toward meeting your deductible.

	Annual savings on payroll deductions*		County's annual HRA contribution**		AVAILABLE MONEY
Employee	$615.84	+	$750	=	$1,365.84
Employee + spouse	$1,529.04	+	$1,500	=	$3,029.04
Employee + child(ren)	$1,429.68	+	$1,500	=	$2,929.68
Family	$1,981.92	+	$1,500	=	$3,481.92

A good idea: Choosing to set aside your premium savings in a regular savings account will help ensure you have money available to pay out-of-pocket expenses if you use all your County-provided HRA funds during the year.

This amount can be used to satisfy your deductible.

* If you choose the HRA plan instead of the Copay plan.

** Money actually resides in your HRA and may only be used for eligible healthcare expenses.

Need more help?

Visit **www.mycignaplans.com**. ID: Rutherford2015, Password: cigna — the log-in is case-sensitive.

DENTAL

See page 3 for dependent eligibility rules.

Rutherford County offers you and your eligible dependents three options for dental coverage, all administered by Cigna.

Do I have to use certain dental providers?

You can see any dentist you choose, but benefits are highest when you use a provider in Cigna's network.

Do I have to meet a deductible?

It depends on the service you receive. For preventive care, if you use an in-network dentist, you do not have to meet a deductible. For all other care, you must meet an annual deductible as shown in the chart below.

How do I find in-network providers?

Visit **www.cigna.com** or call 1-800-244-6224 for a list of in-network providers.

Option 1 and Option 1 Buy-Up use the Cigna DPPO Advantage network, and Option 2 uses the Cigna DPPO network.

Can my covered child use the orthodontia benefit in the first year of coverage?

No. The covered person must have 12 consecutive months of coverage in a County dental plan before he/she can receive benefits for **orthodontia** or **major restorative services**.

	Option 1 and Option 1 Buy-Up		Option 2
	In-network	Out-of-network[1]	See any dentist[1]
Annual deductible	$50/person; $150/family	$100/person; $300/family	$50/person; $150/family
Plan pays...			
Preventive/diagnostic[2]	100%; no deductible	80% after deductible	100%; no deductible
Basic restorative	80% after deductible	60% after deductible	80% after deductible
Major restorative[3]	50% after deductible	40% after deductible	50% after deductible
Orthodontia (dependents up to age 19)[3]	50% after separate $50 deductible	40% after separate $100 deductible	50% after separate $50 deductible
Annual benefit max	$1,000/person		$1,000/person
Lifetime orthodontia max	Option 1: $1,000/person; Option 1 Buy-Up: $2,500/person		$1,000/person

[1] Out-of-network benefits are subject to reimbursable limits.
[2] Bitewing x-rays are covered at each preventive visit; panoramic x-rays are covered every five years.
[3] Major restorative and orthodontia benefits are payable after enrollee has been in the plan for 12 consecutive months.

What is the difference between Option 1 and the Option 1 Buy-Up?

Benefits are exactly the same, except for the orthodontia lifetime maximum. The orthodontia maximum under Option 1 Buy-Up is reduced by any prior orthodontia benefit used in Option 1 or 2.

Important: Unless you have eligible dependent children under age 19 who are receiving orthodontia services, it is not to your advantage to enroll in the Option 1 Buy-Up plan.

Is there a maximum age for orthodontia coverage?

Yes. Orthodontia coverage terminates at age 19.

What happens to my dental coverage if I don't re-enroll?

Your dental plan election and tier continue in 2015 unless you change it.

Important: Orthodontia maximums apply only to orthodontic services, not to major restorative services.

How much does dental coverage cost?

Your monthly cost for coverage, shown in the chart below, is deducted from your paycheck on a pre-tax basis (post-tax deduction is not an option for the Option 1 Buy-Up).

Monthly premium	**County** (based on 12 months)			**Board of Education*** (based on 10 months)		
	Option 1	**Option 1 Buy-Up**	**Option 2**	**Option 1**	**Option 1 Buy-Up**	**Option 2**
Single	$7.95	$9.41	$19.99	$9.53	$11.29	$24.00
Employee + family	$47.48	$52.06	$84.99	$56.97	$62.47	$102.00

* Board of Education (BOE) employees pay their insurance premiums over 10 months (September-June) for 12 months of coverage (September-August). BOE employees may be subject to collection of back premiums, known as "arrears." This is the amount needed to fully pay up July and August insurance. This occurs if an employee changes his/her medical or dental option or coverage tier, resulting in a higher monthly premium than previously enrolled. It can also occur if premiums increase for the new calendar year, or if an employee not enrolled in 2014 adds coverage for 2015. Alternatively, a refund will be issued if an employee makes a coverage change resulting in a lower monthly premium or drops coverage for 2015. Arrears/refunds will be administered through the payroll function. The timeframe for arrears/refunds will be February-April 2015.

DENTAL PREVENTIVE CARE IS FREE!

Regardless of the dental option you elect, you and each covered family member get one free dental exam/cleaning and x-ray every six months. This benefit alone can offset a significant portion of the cost of coverage. And it helps keep your smile healthy.

VISION

See page 3 for dependent eligibility rules.

The County offers you and your eligible dependents optional vision coverage, administered by Cigna Vision. The plan covers eye exams, frames, lenses and contacts, and provides discounts on other products and services.

Do I have to use certain vision providers?

You can see any vision provider you choose, but benefits are highest when you use a Cigna in-network eye care professional. In-network providers will also file claims for you.

How do I find in-network providers?

For a list of network providers, call 1-877-478-7557, or if you've already enrolled for coverage, visit **www.cigna.com**.

How much does the vision plan cover?

The chart below shows benefit levels for the vision plan.

	In-network	Out-of-network
Annual deductible	$0	$0
Eye exams (every 12 months)	You pay $10 copay	Plan pays up to $45
Frames[1] (every 24 months)	Plan pays up to $100 retail allowance	Plan pays up to $55
Lenses[1] (every 12 months)		
Single vision	You pay $15 copay	Plan pays up to $32
Bifocals	You pay $15 copay	Plan pays up to $55
Trifocals	You pay $15 copay	Plan pays up to $65
Lenticular	You pay $15 copay	Plan pays up to $80
Contacts (one pair or single purchase every 12 months in lieu of frames/lenses)		
Medically necessary	Plan pays 100%	Plan pays up to $210
Elective	Plan pays up to $100	Plan pays up to $87

[1] Only one copay is required when you buy frames and lenses together.

How much does vision coverage cost?

Your monthly cost for coverage, shown in the chart below, is deducted from your paycheck on a pre-tax basis.

Monthly premium	**County** (based on 12 months)	**Board of Education** (based on 10 months)
Employee	$4.63	$5.56
Employee + spouse	$9.72	$11.66
Employee + child(ren)	$8.57	$10.28
Employee + family	$13.43	$16.12

Will I receive a Cigna Vision ID card for 2015?

Yes. Cigna Vision ID cards will be mailed to enrollees in January 2015. Present your card at the time of your appointment.

LIFE AND AD&D

All benefits-eligible employees receive basic life and accidental death & dismemberment (AD&D) insurance equal to $35,000 **at no cost**. Life and AD&D coverage is provided through The Hartford.

Can I buy more coverage?

Yes. You may purchase additional coverage, as shown below:

Optional coverage:	Choose:
Supplemental employee life and AD&D[1]	Up to 5 times your base annual salary or $500,000 (in $10,000 increments), whichever is less
Basic spouse/domestic partner life	Up to $25,000 (in $5,000 increments) – without EOI
Supplemental spouse/domestic partner life and AD&D[1,2]	Up to $250,000 (in $5,000 increments)
Child life[3]	$5,000 or $10,000

[1] Evidence of insurability (EOI) is required if you elect more than $300,000 in employee supplemental life and/or more than $50,000 in supplemental spouse/domestic partner life when first eligible. EOI is also required if you elect or increase your supplemental life by more than $10,000 or your spouse's supplemental life by more than $5,000 during Annual Enrollment.

[2] You must elect supplemental life for yourself in order to elect it for your spouse/domestic partner; however, your spouse/domestic partner's total life insurance amount cannot exceed 50% of your supplemental life insurance amount.

[3] From birth through age 25 (age 26 and older if child is disabled and became disabled prior to age 26; you must submit proof of the child's disability).

My spouse also works for the County. Can we both buy coverage?

Yes. You may both purchase basic, supplemental and/or spouse/domestic partner coverage. You may also both elect coverage for eligible dependents.

Can I buy coverage on my domestic partner?

Yes. There are forms you and your domestic partner must complete and sign. Call Risk Management at 615-898-7715 for details.

Can I enroll for, increase and/or drop my supplemental life coverage online during Annual Enrollment?

Yes. You may enroll for, increase or drop coverage during Annual Enrollment. However, if you elect or increase your coverage by more than $10,000 or your spouse's supplemental life by more than $5,000, you must submit evidence of insurability (EOI) and be approved by The Hartford before the new amount becomes effective.

If I elect an amount that requires evidence of insurability (EOI), how do I provide it?

If EOI is required, you will receive a notification letter from The Hartford at your home address. The letter will direct you to a website and provide instructions for logging in and answering EOI questions. Once you complete the questionnaire, you will receive a preliminary determination of your status on the screen. As is legally required, a confirming letter of determination from The Hartford will be mailed to your home address.

How do I name a beneficiary for my life/ AD&D insurance?

You can name or change your beneficiaries at any time by logging onto ADP Employease (see instructions on page 2). At the welcome page, click the Beneficiaries tab.

Important: If you currently carry employee supplemental life that exceeds 5 times your annual salary, your coverage will be reduced so it does not exceed the 5 times salary limit. The reduction is required for our plan to be in compliance with The Hartford's guidelines and plan underwriting. Premium rates will be adjusted accordingly.

FLEXIBLE SPENDING ACCOUNTS

The County offers two flexible spending accounts (FSAs), administered by TASC. You may participate in one or both FSAs.

Will my 2014 FSA election automatically continue in 2015?

No. You must re-enroll during Annual Enrollment to participate in 2015. If you fail to complete your online review and confirmation of your 2015 benefits, your FSA has NOT been renewed for 2015. **Also, if you check "Accept With No Changes," your FSA participation has NOT been renewed for 2015.**

How does an FSA save me money?

With an FSA, you are simply setting aside money to pay for many common health and dependent care expenses. You save because the money is not taxed when it's deducted from your paycheck OR when you use it to pay for eligible expenses.

How much can I contribute to an FSA?

You can contribute:

- Up to $2,500/year — tax-free — to the Medical Reimbursement Account
- Up to $5,000/year — tax-free — to the Dependent Care Reimbursement Account (if you are married and file separate tax returns, the maximum you can contribute is $2,500/year)

If I elect to continue participating in the FSAs, will I receive a new debit card?

If you participated in an FSA last year, your TASC debit card will be reloaded with your 2015 contributions. New enrollees will receive an FSA debit card from TASC mailed to their home addresses.

My spouse also works for the County. Can we both contribute to the Medical Reimbursement Account (FSA)?

Yes. You may each contribute up to the $2,500 annual limit.

Important: The Dependent Care Reimbursement Account (DCA) is NOT a reimbursement fund for medical expenses. Eligible DCA expenses include: day care facility, nursery school and preschool fees. Before enrolling, contact TASC for guidelines on qualifying eligible expenses.

What can I spend my FSA money on?

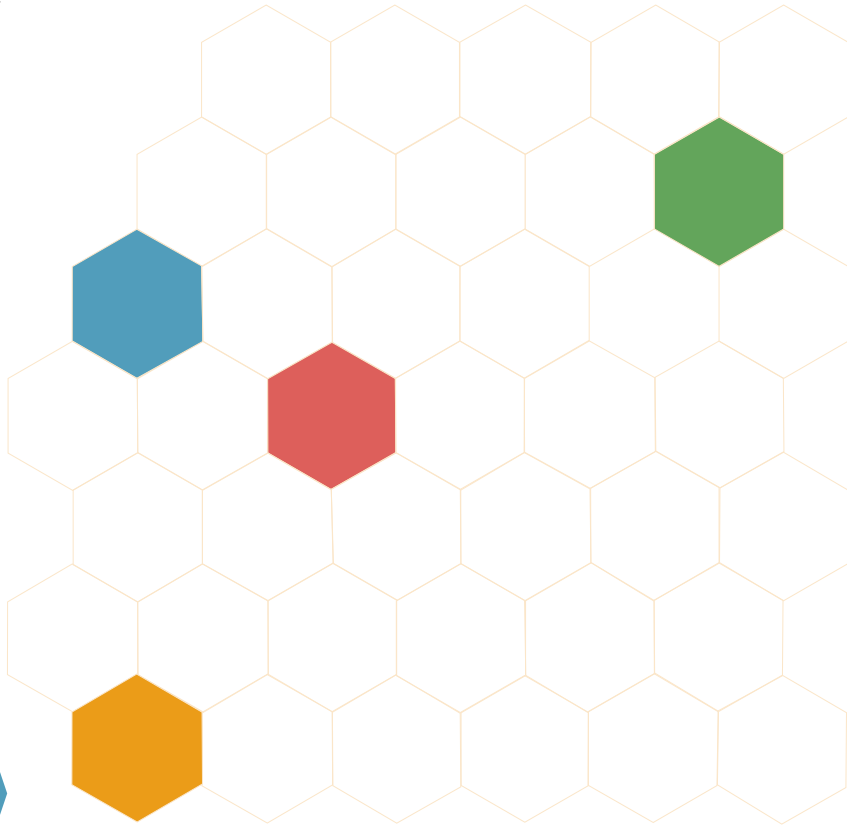
If you contribute to the Medical Reimbursement Account (FSA), you can use the money to reimburse yourself for many medical, dental and vision expenses not covered by insurance.

If you contribute to the Dependent Care Reimbursement Account (DCA), you can use the money to reimburse yourself for care expenses for your eligible dependents. Certain rules apply.

For more information about eligible expenses, go to **www.irs.gov** and search for Publications 502 and 503.

Is the money I set aside in the Medical and/or Dependent Care FSA always mine?

The money is yours to spend on eligible expenses incurred during 2015. But it's important to estimate your expenses carefully because certain rules apply if you have funds left at year end. See page 15.



Do I have to use all my FSA funds by the end of the year?

It is important to estimate your expenses for 2015 carefully. If you participate in the Dependent Care Reimbursement Account (DCA), you must use all the money in your account by year-end; the IRS requires that any funds remaining after this date be forfeited. You do, however, have until January 31, 2016 to submit claims for expenses incurred in 2015.

If you participate in the Medical Reimbursement Account (FSA), you may carry over up to $500 of unused funds into the next year. In other words, if you overestimate your health care expenses for 2015 and have money remaining in your account at year-end, you may carry over up to $500 and continue to incur and get reimbursed for eligible expenses from the carried-over amount. However, there are a couple of rules to keep in mind:

- Unused funds exceeding the $500 rollover limit will be forfeited.
- The carryover provision does not reduce how much you can contribute to the Medical Reimbursement Account (FSA) in the next plan year. For example, if you carry over $400, you can still make the maximum contribution ($2,500) in the next year.

Is there a deadline for filing FSA claims?

You have until January 31, 2015, to submit claims for eligible expenses incurred in 2014. You have until January 31, 2016, to file claims for eligible expenses incurred in 2015.

Where can I find more information about the FSAs?

Visit **www.rutherfordcountytn.gov/rm** and click Employee Insurance Benefits on left side of the screen.

You can also contact TASC at 1-800-422-4661 or by visiting **www.tasconline.com/mytasc.**

LOWER YOUR HEALTH CARE COSTS.

Reduce your out-of-pocket health care expenses by signing up for the Medical Reimbursement Account flexible spending account. You can use pre-tax dollars to reimburse yourself for health care expenses not covered by insurance, including dental and vision costs. See page 14.

SHORT-TERM DISABILITY

The County offers all benefits-eligible employees short-term disability coverage through Cigna. This optional coverage continues a portion of your paycheck if you can't work because of a non-work-related disabling illness or injury.

How much coverage can I elect?

You have four coverage options. When you enroll, you choose how much of your pay the plan will replace if you become disabled: 30%, 40%, 50% or 60% of your pay, up to $1,250/week.

Are there pre-existing condition limits?

Yes. If you become disabled during your first year of coverage as a result of a condition you had in the 12 months prior to your coverage effective date, no benefits will be payable for that disability.

What is a pre-existing condition?

A pre-existing condition is one for which you received treatment, a diagnosis, service or prescription drugs during the 12 months before your coverage began.

Can I increase my short-term disability coverage?

Yes; however, your benefit increase will be subject to the pre-existing condition limit. Any claims resulting from a pre-existing condition will be reimbursed at the prior lower benefit level.

If I become disabled, how long will I receive benefits?

Benefits begin after eight days of disability due to illness, or on the first day of disability due to an accident. Benefits generally continue up to 26 weeks. Certain rules apply.

PREPARE FOR THE UNEXPECTED.

If you're temporarily disabled and can't work, short-term disability coverage continues a portion of your paycheck for up to 26 weeks. Without this coverage, you must use available sick or annual leave.

LONG-TERM DISABILITY

The County provides long-term disability coverage to all benefits-eligible employees at no cost, with no enrollment required. This coverage, provided through Cigna, continues a portion of your paycheck if a disabling illness or injury keeps you from working for longer than 180 days.

How much does the plan pay if I become disabled?

The plan replaces up to 66.67% of your monthly earnings (up to $6,000/month). You must meet the plan's definition of "disabled" to qualify for benefits, and certain rules apply.

How long does the plan pay benefits?

Benefits begin after 180 days of disability and generally continue until your disability ends or you reach normal retirement age, whichever comes first. If you're age 60 or older when your covered disability begins, your benefits duration may differ.

PLAN AHEAD.

A serious disability can happen to anyone; in fact, according to the Social Security Administration, three out of 10 workers will face a disabling injury or accident before they retire. If the unexpected happens to you, long-term disability coverage will continue a portion of your salary, and it picks up when short-term disability coverage ends.

VOLUNTARY INSURANCE PLANS

The County offers several voluntary insurance plans, administered by BeneSync. Individual or family coverage is available. You pay the cost through payroll deduction. Cancer, critical illness and accident insurance is offered through Allstate Benefits. LifeTime Benefit Term insurance is offered through Fidelity.

CANCER INSURANCE

Cancer insurance provides a benefit following a cancer diagnosis. The plan pays a cash benefit directly to you to help cover out-of-pocket expenses — medical and nonmedical — associated with battling this disease. Each covered person can also claim an annual wellness benefit for various cancer screenings.

CRITICAL ILLNESS INSURANCE

Critical illness insurance pays a lump-sum cash benefit to you following the diagnosis of a covered critical illness, such as heart attack, stroke, coronary artery bypass surgery, major organ transplant, paralysis, Alzheimer's and more. This coverage also provides an annual wellness benefit.

ACCIDENT INSURANCE

Accident insurance provides a cash benefit for work-related and nonwork-related injuries and medical expenses such as emergency room care, hospital stays, accidental death and more.

LIFETIME BENEFIT TERM INSURANCE WITH LONG-TERM CARE RIDER

This affordable, permanent term life policy offers coverage to age 121 and a level premium to age 100. Unlike other life insurance products, premiums do not increase based on your age. This coverage provides additional benefits, including:

- An accelerated benefit for long-term care if the covered person becomes eligible for benefits by being both chronically ill and confined to a nursing or assisted living facility, or by receiving home health or adult day care services
- A no-cost accelerated death benefit, which advances 50% of the face amount if the covered person is diagnosed as terminally ill
- A paid-up death benefit after just five years, which means if you stop paying premiums at some point in the future, you are guaranteed paid-up coverage of a reduced amount

LifeTime Benefit Term coverage is fully portable — you can keep your coverage even if you leave employment with the County, and premiums remain the same.

When can I enroll for voluntary plans?

You can only enroll for the voluntary plans during Annual Enrollment.

How do I enroll for the voluntary plans?

Enrolling for the voluntary plans is a separate process from your other benefits.

If you were hired **after** October 1, 2013, you can enroll for the voluntary plans without answering any medical questions. Call BeneSync at 1-855-228-8309 with enrollment questions, to learn more about the plans and enroll. If you were hired **before** October 1, 2013 and wish to enroll in the voluntary plans, you must answer medical questions and be approved before coverage is effective. You must complete enrollment in the voluntary plans on or before November 30, 2014.

If I already have coverage, do I have to re-enroll?

No. Your coverage will continue.

Do I have to answer medical questions to enroll?

If you enroll in the plans when first offered to you, no medical questions will be asked and coverage is guaranteed. If you decline coverage when first eligible but wish to elect it at a future Annual Enrollment, you must answer medical questions and be approved by the insurance carrier.

Can I specify pre-tax or post-tax payroll deductions?

Yes. When you call BeneSync to enroll for cancer, critical illness or accident plans, you will be asked if you want your coverage classified as Section 125 for pre-tax deductions. LifeTime Term premiums must be paid through post-tax payroll deduction. Remember, per IRS guidelines, if you elect pre-tax deductions, you generally may not add, drop or change your coverage during the year (outside Annual Enrollment).

Where can I review my coverage?

Once your voluntary coverage is in force, you will receive a policy(ies) in the mail.

Visit **www.allstatebenefits.com** to review your Allstate coverage. Once you register and get a user ID and password, you can view your coverage, check claim status, update your address and personal information, and much more.

To review your **Fidelity LifeTime Term** policy, call 1-877-352-3303.

Do the voluntary plans have pre-existing condition limits?

The cancer, critical illness and accident plans have pre-existing condition limits, but those limits expire after you've had coverage for 12 months. Here's how it works: No benefits are payable during your first 12 months of coverage from claims resulting from a pre-existing condition. After you have been covered by the plan(s) for 12 months, this limit no longer applies.

What is a pre-existing condition?

A pre-existing condition is one for which you received medical advice or treatment from a medical professional in the 12-month period before your coverage begins. A pre-existing condition can exist even if a diagnosis has not yet been made.

What is an annual wellness benefit?

The cancer and critical illness plans pay a once-a-year cash reimbursement to each covered person for completing certain screenings. The cancer plan reimburses $25 or $100, depending on the cancer screening you have. The critical illness plan reimburses $50 when you have a cancer or heart screening test. See plan brochures or visit **www.allstatebenefits.com** for details.

How do I file a claim?

For the Allstate plans, visit **www.allstatebenefits.com** to complete the claims submission process. For Fidelity, call 1-877-352-3303.

How do I drop coverage in one or more of the voluntary plans?

You must submit a written request, via email or a signed statement, no later than November 30. BOE employees send to Sherry Dodd (sdodd@rutherfordcountytn.gov); all other employees send to Evelyn Anderson (eanderson@rutherfordcountytn.gov). You may be required to complete additional forms.

Where can I find additional information about the voluntary plans?

Call the BeneSync call center at 1-855-228-8309.

OTHER BENEFITS

The County offers a variety of other benefits and special programs to complete your benefits package.

TCRS RETIREMENT PLAN

The County is a member of the Tennessee Consolidated Retirement System (TCRS), a program that provides a pension to eligible County retirees. The plan you participate in is determined by when you become a TCRS member as follows:

TCRS Legacy Plan: County General and BOE Classified employees will participate in the TCRS Legacy Plan. Additionally, teachers (including those who are new to Rutherford County) who were TCRS members as of 6/30/14 will participate in the Legacy Plan. The plan is the same; only the name has changed. Visit **www.treasury.state.tn.us/tcrs** or call 1-800-770-8277 for more information.

TCRS Hybrid Plan: Teachers who become TCRS members on or after 7/1/14 will participate in the TCRS Hybrid Plan. This plan is a combination of a defined benefit plan and a state of Tennessee 401(k) plan. It is administered by Great West. To enroll or set a meeting time with a financial advisor, call 1-800-922-7772 or visit **www.treasury.tn.gov/dc**.

Teachers and other BOE employees can participate in the 401(k) plan via employee contributions. Visit **www.treasury.state.tn.us/tcrs** for more information.

403(B) AND 457(B) RETIREMENT PLANS

All Rutherford County School employees are eligible to participate in the 403(b) or 457(b) tax-deferred retirement savings plans through VALIC. Contributions to both plans are made through payroll deductions.

What are 403(b) and 457(b) plans?

A 403(b) or 457(b) plan is a tax-deferred retirement plan available to educational institution employees.

There are two types of accounts available with each plan:

- **Traditional account**, with pre-tax contributions. You'll pay taxes as you withdraw funds during retirement.
- **Roth account**, with after-tax contributions. Funds are not subject to federal income taxes as you withdraw during retirement.

Who's eligible to participate in the 403(b) or 457(b) plans?

BOE EMPLOYEES

Board of Education employees can save for retirement through Traditional or Roth 403(b) or 457(b) plans, offered through VALIC. To enroll or set a meeting time with a financial advisor, call 615-221-2541 or visit **www.valic.com/rutherford**.

COUNTY EMPLOYEES

The County offers an optional 457(b) deferred compensation plan, administered by Nationwide Retirement Solutions. For more information, including how to enroll, contact NRS at 1-877-677-3678 or visit **www.nrsforu.com**. This plan is not available to BOE employees.

How do I start a VALIC 403(b) or 457(b) account?

Call VALIC at 615-221-2541 to make an appointment with a financial advisor who can guide you in setting up an account.

You can also visit **www.valic.com/rutherford** to get information on available investment options, enroll online and view prospectuses. For the Portfolio Director's Choice annuity program, follow the annuity links. For the Profile Retirement mutual fund program, follow the mutual fund links. VALIC also offers the Schwab Personal Choice Retirement Account (PCRA), a self-monitored brokerage investment program for more experienced investors.

How do I contribute to the plans?

To participate in either plan, there's a required minimum payroll deduction of $20/month for salaried staff and $10/payday for classified staff. You can start your 403(b) or 457(b) account at any time during the year. If you want to change your contribution amounts, BOE employees must contact Central Office Payroll (615-893-5812) and County General employees must contact Human Resources (615-494-4480). A revised payroll deduction form must be received no later than 10 days before the payday you want the change to begin.

Are there contribution limits to the plans?

The 2014 limit for 403(b) or 457(b) contributions is $17,500. The 2015 limit has not yet been announced.

Are there limits on withdrawals?

There are withdrawal limitations on both plans until you reach age 59½ or are no longer employed by Rutherford County. In the event of financial hardship, death or disability, hardship withdrawals are possible. There is a 10% IRS surcharge on early 403(b) withdrawals. Short-term needs can sometimes be met by non-taxable loans.

Why should I contribute to a 403(b) or 457(b)?

There are several benefits to contributing to these plans:

- They can provide a healthy supplement to your retirement income.
- If you use the Traditional account with either plan, you'll lower your current taxes.
- Growth on the earnings of your account will be tax-deferred.
- Roth accounts may lower your taxes during retirement.

This information is not intended as tax or legal advice. Neither your employer nor the investment providers that offer products under the plan can provide you with tax or legal advice.

EMPLOYEE ASSISTANCE PROGRAM

The employee assistance program (EAP) offers confidential counseling and referral services to County employees and their family members. The program is administered by LifeServices. EAP services are free and completely confidential. Call 1-800-822-4847 or visit **www.lifeserviceseap.com** (user name: rutherford; password: employee).

EMPLOYEE WELLNESS PROGRAMS

Rutherford County's Smart Steps Employee Wellness program provides employees and their family members enrolled in medical coverage with a variety of wellness programs and initiatives to improve their physical and mental well-being. The program includes physical activity contests, stress management programs, tobacco cessation help and more. Free health screening opportunities are available each year at the annual wellness fair. This year's fair is Friday, October 17, 3-7 p.m. at Lane AgriPark, 315 John Rice Blvd. We encourage employees to take advantage of the preventive services offered throughout the year. Visit **www.rutherfordcountytn.gov/rm/wellness.htm** for details on current and upcoming programs.

SAVE FOR YOUR FUTURE.

Do you know how much money you'll need to live comfortably after you retire? To maintain your standard of living, you'll need at least 70% of your pre-retirement income, according to the U.S. Department of Labor. So face your financial future and sign up for a tax-deferred savings plan.

IMPORTANT CONTACTS

Vendor	Website	Phone number
General		
Risk Management	www.rutherfordcountytn.gov/rm	615-898-7715 615-867-4602 (fax)
Medical		
Cigna	www.cigna.com (Open Access Plus network)	1-800-244-6224
Med Point medical clinics	www.rutherfordcountytn.gov/rm	615-904-6770
Prescription drugs		
Cigna	www.cigna.com	1-800-244-6224 (retail program) 1-800-285-4812 (Tel-Drug mail order program)
Dental		
Cigna	www.cigna.com	1-800-244-6224
Vision		
Cigna Vision Network	www.cigna.com	1-877-478-7557
Life and AD&D		
The Hartford	Contact Risk Management	615-898-7715
Flexible spending accounts		
TASC	www.tasconline.com/mytasc	1-800-422-4661
Short-term disability		
Cigna	N/A	1-800-362-4462 (claims only)
Long-term disability		
Cigna	Contact Risk Management	615-898-7715
Voluntary insurance plans		
Allstate Benefits (cancer, critical illness & accident insurance)	www.allstatebenefits.com (policyholders)	1-888-808-1664 ext. 3298 (BeneSync - local contact) 1-800-521-3535 (customer service) 1-800-348-4489 (claims only)
Fidelity (LifeTime Benefit Term)	N/A	1-888-808-1664 ext. 3298 (BeneSync - local contact) 1-877-352-3303 (claims and customer service)
Retirement/savings		
Retirement plan (TCRS)	www.treasury.state.tn.us/tcrs	1-800-770-8277
403(b) (Valic)	www.valic.com/rutherford	615-221-2541
457(b) (Nationwide)	www.nrsforu.com	1-877-677-3678
Employee assistance program		
LifeServices EAP	www.lifeserviceseap.com User name: rutherford; password: employee	1-800-822-4847
Wellness program		
Smart Steps	www.rutherfordcountytn.gov/rm/wellness.htm	615-898-7715
Zensey/mycigna.com	mycigna.com	1-800-853-2713